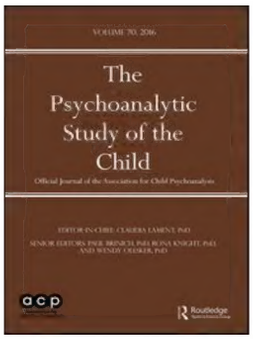

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Disturbances in Object Representation

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I HAVE CHOSEN TO DISCUSS THE TOPIC OF DISTURBANCES IN OBJECT representation for two reasons:

1. I was surprised to discover this disorder in my patients and I wondered why I had not discovered it earlier in the analysis of some patients. Presenting my clinical material is an invitation to stimulate a discussion about this topic in order to find whether others have had similar clinical experiences.

2. The data which I shall present stem from the analysis of adults. Since the history of this disorder indicates that it started early in childhood, one has to pose the question: How can we obtain information of this form of disturbed object representation during childhood?

I do not need to review the significance of object relations in psychoanalysis or the recent attention to object and self representations. The data from the study of the first years of life which led to a clearer outline of the development of the dyadic and triadic interrelationship between infant and objects are well known. Many explanations have been given of those factors which contribute to the evolvement of an inner representational world. For our topic it may be useful to remind us that *the object representational world and the inner psychic life are not synonymous, and that our understanding of the establishment of a representational*

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world in the first three years of life is primarily based on inferences. We have much information on object relationships, but the child's inner experience of the object or its representation is difficult and in the preverbal stage impossible to obtain. As usual, we are able to learn from pathology about the normality of developmental sequences. Therefore, I shall begin by presenting three clinical vignettes of patients with abnormalities of visual representation with the understanding that I do not do justice to the usual complexity and multiple determinants of experiences and psychic structure formation, for I have to limit myself to those data which serve the topic.

Vignette 1

A middle-aged, highly articulate woman entered analysis because of difficulties with her husband and children and her writing block. Her intense engagement in the care of her children, who were then 5 and 8 years of age, led to discords with her husband who wanted her to pay full attention to his needs. Indeed, she addressed herself to every task with great energy and with a channelization which excluded recognition of other daily events. From the beginning, she expected the analysis to rescue her from the many demands made on her. It is therefore not surprising that she immediately formed an intense relationship to me which included aspects of transference of her relationship to both her mother and her father. She constantly sought contact with me. Insatiable in her demands, she was unable to find security or gratification in it. There were many dreams, some with anal conflicts expressing fears of loss of parts of herself; these were related to a history of constipation and forced enemas. There were many other dreams which had an eerie de Chirico-like empty space, buildings and streets, without people. She associated this feeling to a painting in the living room of her parents' home in which she saw a long arm reaching out for her. She realized later that it was a painting of a swan on a lovely lake. This was connected to her myopic condition since early childhood. Unless faces were very close to her, they disappeared; indeed, she experienced empty spaces around her, which she reexperienced in her dreams.

Before I went on vacation, she expressed a wish to take an object from my office, intending to return it when the sessions resumed. I thought this to be an expression of her need for a transitional object, a reenactment in the analysis of her search for reliable object relations, which she seemed to confirm by her explanation that she wished something that she could hold, touch, and carry with her in order to feel my "presence." This then finally led to the question whether she was able to experience my presence in my absence, and whether she could remember me, that is, whether she could visualize me when I was absent. She answered immediately that she had great difficulty doing so, that she thought of me frequently, but that she was unable to remember the way I looked, even shortly after she had left my office. She could remember my voice or invoke it; she could remember the smell of the room and the sound of my steps. She had always known about the problem, but she had never made any reference to it, either taking for granted that I would know it, or because she lived with this difficulty of forming visual images of people all her life. This included her parents, husband, children, and friends.

In addition to this failure of evocative memory to form visual representation, the patient also had a disorder of recognition memory. In social situations, or when she gave a lecture, she was not able to recognize her friends, even when they were close enough, and she had to remind herself before meeting them who might be present in order to prepare herself to recognize them.

During the treatment she discovered her talent as a photographer and then employed photography to document her literary work. Furthermore, when she visited with friends and family, she took photographs which were quite cherished by them. It became clear that this activity served her need for permanency of the objects, for whenever she wanted to remember, they were available to her. Similarly, she considered the written word as being forever retrievable and thus being permanently a part of history. She began to write a diary of the sessions in order, as she said, "to imbed them into stone."

It is not surprising that she had many fears of a world which for her was too unstable; headlines which referred to war or

other disasters disturbed her so profoundly that she rather avoided reading the news; and she refused to go to movies or plays which depicted destruction. She confessed that when she had intense fears, it was difficult for her to differentiate between fantasies and reality.

She had found a quote from Agatha Christie's autobiography which she brought to the session with much pleasure:

> When I look back over my life, it seems to me that the things that have been most vivid, and which remain most clearly in my mind, are the *places* I have been to. A sudden thrill of pleasure comes to mind—a tree, a hill, a white house tucked away somewhere, by a canal, the shape of a distant hill. Sometimes I have to think a moment to remember *where* and *when*. Then the picture comes clearly, and I know.
>
> People, I have never had a good memory for. My own friends are dear to me, but people that I merely meet and like pass out of my mind again almost at once. Far from being able to say, "I never forget a face," I might more truly say, "I never remember a face." But places remain firmly in my mind. Often, returning somewhere after five or six years, I remember quite well the roads to take, even if I have only been there once before.
>
> I don't know why my memory for places should be good and for people so faint. Perhaps it comes from being farsighted, so that people have a rather sketchy appearance, because they are near at hand.

While I cannot examine Agatha Christie's life history, I would say that her visual disorder and the resulting inability to visualize faces appear to be isolated phenomena and do not seem to be correlated with or part of other disturbances in object interactions as they occurred in my patient. I have examined in detail the role of myopia in the disturbances in object representation. While it obviously contributes to them, it is not by itself a primary cause. There are many children who suffer from myopic conditions from earliest infancy, but they do not develop the above symptomatology.

The patient collected a family history which revealed that many other members of her family suffered from a similar difficulty. Her aunts and cousins also could never remember people's faces and had difficulty recognizing them. I have no infor-

mation whether they too shared the myopic condition. Furthermore, the patient had a 15-year-old cousin who was unable to have an image of people. When I asked her how she knew this, she answered that her cousin's drawings and paintings revealed it very clearly. As a child and until her present age, she was unable to draw a figure; when asked to do so, she made scribbles and designs.

When my patient explored her object relationship, rather than the object representation, she revealed much of the usual complexity of interactions, her ambivalence, her attachments, her criticisms, and her early childhood separation anxiety. For this reason, as I have described, I at first did not conclude or anticipate that she was suffering from a visual object representation disorder.

Her need to capture and recapture the objects to make them constant and her inability to internalize objects became more apparent. They were an expression of an inability which continuously made her search for the object. Quite frequently, she would phone me in order to hear my voice; early in treatment, before she had admitted her need for contact, she would do so and justify it by referring to ever new crisis situations in her life.

Vignette 2

The second vignette explores a different genetic and dynamic condition leading to a disorder in visual representation. This young man sought analytic treatment after he had left his previous woman analyst with whom he had been for almost two years. He had discontinued therapy because she could not rescue him from feelings of depression and isolation, and he left her before she went on a prolonged vacation.

This response to separation reminds us of the young child's ability to leave mother, while being unable to be left by her. His history revealed that his mother suffered from severe depression, which necessitated frequent hospitalization, the first time when he was only 3 years old. She committed suicide in a mental institution when he was 16. The father had divorced the mother and remarried when the patient was 6 years old. He had always felt that his father was not available to him; he demanded appro-

priate behavior and academic performance, but was unable to give him comfort.

Indeed, the patient became an unusually successful performer in his profession, but he could not find any comfort in it. All the recognition which he received did not relieve him of his sense of loneliness. During many sessions, he was silent, waiting for me to connect with him and to relieve him of his sadness. In this condition he was unable to speak about himself and appeared to be reenacting his mother's depression. When I was able to understand his feelings and express to him what he might be thinking, he instantly smiled and the sad mood was broken. Without reading his feelings, I was not present. I referred to his mother's silent presence, her absences, and then asked him whether he could now remember his mother and evoke her image. He proceeded, as did the other patient, with an immediate and unusually long statement:

> When I was with the previous analyst, I could not visualize her after the sessions, nor can I succeed in remembering my girl friend, who lives in Europe. The closer the physical contact is with people, the more I have difficulty visualizing them. When there is no relationship, I feel secure in evoking the image. With you, I have the same problem, but not to the same degree. With a woman I have more fears. She may do what mother did; to be either away; or she is not available when physically present; or she overwhelms me with her attachment and her affection. A man will keep more distance. The only true image of my mother is either her extreme silence or her screaming. I cannot recall an image in the middle, balanced. I can't recall an easy comfortable time, and still the separations from my mother and from my girl friend give me a bad time. When my girl friend arrives, for a few days, I cannot connect with her, feel close to her. We have discussed this many times. It is like with my dreams. I do not want to think about them, as if the images were a burden. When my girl friend leaves, I do not really want to think about her. When I was a child, and my mother left me, I had no contact with her, no idea where she was, no letters. When she returned, I could, after a while, retain the connection. When I went to school, I did not have an image of either mother or father. I felt separated and alone, bewildered and unhappy. I carried this longing all my life, the longing to make the connection.

> I still remember when I was 3 years old how much I wanted to connect with my mother because she was so distant and silent. I wanted her to pay attention to me. I was waiting *for her* to connect with me. I carried the feeling for many years after that; when I was 9 or 10 years old, I gave up. Then I transferred my wish to be close to my stepsister; and then I was not passively waiting, I actively pursued her, and later on, when I was older, I was also active with women. There is something about my present girl friend that makes it more difficult. When I assert myself, she does not like it; it is so frustrating. It reminds me of my mother when she frightened me and intimidated me, when she was hysterical or silent. Later on, when I was older, I tried to comfort her when she was crying, but she did not stop, yet I felt I had the responsibility. It was my fault and I behaved as a grown-up who had to console her and take care of her.

In his early adolescence he turned to his father for closeness. He tried to please not only him, but his teachers as well. He was waiting to receive attention as a reward; he could never make a direct demand, for if love was to be given when asked for, then it was no longer valued.

The analytic data revealed a close link between the representational disorder and other emotional difficulties. It was apparent that he repeated his early experience with his mother in the transference. When he was silent, he expected me to find words to reach him, not by interpreting his inhibitions, anger, passivity, but by evoking in him a feeling of my contact with him, interest in him, as if he were longing for a verbal embrace. He had warned me early in treatment that he left his previous analyst because she employed a technique of waiting for his associations and expressions of his feeling and fantasies. In order to do this he needed object contact first. As he said, his reaction to her was aggravated because she was a woman.

Vignette 3

This patient, a young woman, suffered from fears and obsessive-compulsive symptoms. Her early childhood revealed a strong symbiotic need for mother, who tried to detach her daughter from dependence on her and this forced my patient to increase

her demand for mother's attention. She developed somatic symptoms, longing for comfort from mother which led to severe sibling rivalry, jealousy, and envy. At the beginning of the analysis she found reasons to call her mother many times a day, in spite of her mother's unwillingness to respond.

She was occupied with the unreliability of conditions, not only of her world at home, but of the world at large. Her own ambivalence made it difficult to arrive at clear positions about her husband, children, and work. There were fears that she had not locked the door, turned off the gas, or was unable correctly to manage the elevator's "up" and "down" movement. She had to return four or five times to check whether she had indeed turned off the stove. At one time she added to her continuous complaint that the symptoms persisted; it helped her when she went through the following thought process: While she was turning off the stove, she performed other tasks, such as looking at the clock, or putting something away, or cleaning a surface. She then hoped that she would be able to know that she had indeed turned off the stove. By association, by using the memories as a bridge, she could remember that she had attended to the stove. Her inability to remember "on" or "off" and "up" or "down" led me to consider whether she could remember human objects; alerted by my previous experience, I questioned her ability to remember her parents and friends. Again, she was quite ready to speak about this and to confirm that she had always had difficulties remembering mother when she was at school and, as the other patient, she too had similar problems visualizing me and members of her family. Long ago, she learned to help herself by thinking of what people wore, what they had said, and the sound of their voices. She mobilized these other compensatory sensory-perceptual modalities to create a memory of object representation.

As stated before, under conditions of danger or panic, her capacity to remember would be more impaired. Furthermore, her fears affected her ability to decide clearly what was reality and what was fear, what was verifiable and what was illusion. These difficulties were expressed in global terms, seen as part of the conditions of life; indeed, she submerged herself fully in the study of philosophy, existential psychology, and she became ex-

pert in literary criticism. In her academic work she found a nonambivalent world beyond her usual idealizations to escape from her polarizations of love and hate. Her relationship to me (I avoid referring to this as transference) was one of extreme idealization, for she could not accept any evidence that my knowledge was limited. Such an acceptance would have created a sense of fear and defeat. My absence during vacations was viewed as a "total" absence. This seemed to reflect her "on" and "off" dilemma, her love or hate, her sense of existence or nonexistence.

Discussion

These three short vignettes focused on the incapacity to evoke visual object representations. I have eliminated many clinical correlations, but I hope one can still consider the following propositions:

1. The difficulty in, or absence of, evocative memory seems to occur in a variety of diverse clinical conditions.

2. It is not easy to determine the cause of this difficulty. When the absence of evocative memory is a primary condition, does it then interfere with evolvement of identification, the achievement of individuation and separateness, and the evolvement of the beginning of object constancy? When, on the other hand, it is the result of inappropriate early relationships, this too can lead to the disturbance of evocative memory. While there is always an interplay between dispositional and environmental factors, the first patient seems to have a primary disorder of the perceptual-sensory modality, a fault of the ego apparatus, while the other patients seem to have formed the symptom as a result of early conflicts.

3. The failure to achieve evocative and recognition memory seems to reflect upon characteristics of the object relatedness and with it on the analytic process. Compensatory mechanisms are called into action, and representational features can be put together by memories of touch, smell, and auditory channels. It seems that a consolidation of the object and self representations by internalization could not be achieved. All these patients manifested an intense hunger for an object relationship with the

analyst; and in the transference, we see features of the faulty primary object relationship.

4. The male patient who had the depressed mother leads me to connect the disorder of evocative memory to depressive states, particularly where there is an early object relationship characterized by the physical and emotional absence of the mother, by her engulfing affection and alternating total silence.

The third patient who could not remember whether she had turned off the gas on the stove alerted me to the possibility that, under certain circumstances, obsessive-compulsive features can be related to the absence of evocative memory in addition to the usual conflicts.

5. None of the patients spontaneously referred to this symptom, but they were able and relieved to reveal it when they were specifically asked about their capacity to evoke memories of objects.

This alerts us to the fact that we may miss finding this disorder when we wait for associations. I have not been able to see the evocative memory disorder in child patients. Nor have I pursued the course of the symptoms during developmental sequences. I have not addressed myself to the course of the analysis and the influence of this disorder on the limitation of psychoanalytic treatment.

Some colleagues have explained this inability visually to represent objects as being caused by negative hallucinations. Freud (1905) used this term in some of his earlier papers in discussing the hypnotic condition: "Hypnotic obedience can be employed in making a number of highly remarkable experiments, which afford a deep insight into the workings of the mind and produce in the observer an ineradicable conviction of the unsuspected power of the mind over the body. Just as a hypnotized subject can be obliged to see what is not there, so he can be forbidden to see what *is* there and is seeking to impress itself on his senses—some particular person, for instance. (This is known as a 'negative hallucination'.)" (p. 297). I have some questions about negative hallucination as an explanation for visual deficits and will discuss them later.

In 1901, Freud discussed the "remarkable coincidence" of meeting someone of whom he was at that very moment thinking;

"the paradoxical fact that my unconscious is able to perceive an object which my eyes can recognize only later seems partly to be explained by what Bleuler [1910] terms 'complexive preparedness [*Complexbereitschaft*]'" (p. 265). In 1907, Freud spoke about Hanold, who according to Zoe's accusation had the gift of "negative hallucination," who possessed the art of not seeing and not recognizing people who were actually present. Freud considered the negative hallucination to be a "flight from the physical presence of the girl he loved" (p. 67). Earlier (1901, p. 109), Freud referred to negative hallucination when he read parts of the same page about Hellenistic art in the age of Alexander and each time passed over the relevant sentence.

These examples clearly demonstrate that Freud at that time in the development of his work thought of negative hallucination as an example of repression based either on hypnotic or neurotic conflicts. It seems to me that this concept does not explain the clinical data which I have presented, for they are not an expression of "I do not see what I don't want to see"; rather they indicate an inability to visualize what could not be internalized.

The following questions are central to the issue of representation:

1. Can the visual object representation stay isolated and can the other sensory modalities compensate for it?
2. Is visual perception necessary for the "knowing" about the object, that is, for the object-self differentiation and internalization?
3. Is the visual disorder linked to others in specific ways which lead to a larger ego disorder?
4. Do these children develop at critical periods the social smile, even though they are not able to observe and to interact with their mother's affective facial expressions?
5. How do children with visual representation disorders negotiate the important stranger reactions? If memory fails to remember mother, how does the infant differentiate the known from the strange? We assume here that the stranger reaction should occur by the distant reception and not by touch, smell, and voice. Whenever there is this condition, are all unknown others perceived as if they were primary objects? Or are primary objects at first also perceived as strangers? Since it is important to

learn to tolerate frustration, to make new adaptations to new objects, and to form new and varied relationships, is there an interference in these developmental tasks? It may be useful to compare the development of these children with that of the unsighted child.

The evocative and recognition faculty is closely related to the function of memory, which is necessary to deposit experience so that a representational world can be created. Memory is part of the ego, but we assume that memory traces are active during the pre-ego period. After all, perception is present at birth, and the biological part of the ego, the ego equipment, needs to be in action to prepare the evolvement of the ego and its secondary processes. The pre-ego perception is linked to primary narcissistic cathexis, the latter to object cathexis. Later, secondary processes link memory to remembering. Freud (1914) outlined sequences of remembering, repeating, and reenacting. When the infant is unable to exercise the distant preceptual organ, visual perception, he then cannot appropriately "read" mother's face or her smile, nor can he differentiate between the stranger and the primary object—at least visually. Thus we assume that there will be consequences in the self-object differentiation and object relationships.

Memory is an essential element for the achievement of object constancy, the acceptance of the absence of the object by the reliance on the internalized object. Loewald (1976) refers to it in this way: "Memory seems to be inextricably interwoven with experiences of separation, loss, object withdrawal, or cessation of satisfying external interactions" (p. 160). He proposes that memory (by primordial separation) is the result of separation and, later in development, object loss can occur only when the object can be remembered. And "Memory is the child of both satisfaction and frustration" (p. 161). Freud's (1923) formulation helps to explain patients' continuous longing for the object: "It may be that . . . this identification [introjection] is the sole condition under which the id can give up its objects . . . the process, especially in the early phases of development, is a very frequent one, and it makes it possible to suppose that the character of the ego is a precipitate of abandoned object-cathexes" (p. 29).

In all these patients, whether the visual disorder was primary or secondary, that is, related to experiences, there was still the search for the symbiotic link with the object in order to complete a step in development which demands object reliability and object incorporation. This incomplete object-self differentiation did exist side by side with later developmental conflicts. The patients experienced the therapist on one level as a primary object, with magic features. They longed for an intense and continuous contact. Every word was given significance. They seemed to show an immediate strong tie to the analyst. One can assume that the motivating force for closeness, the libidinal tie, maintains its earliest strength.

In the absence of evocative memory and, in some patients, of recognition capacity, there is an inability to differentiate object and self. How then does the patient build a representation of the self? Can there be an inner visualization of the body image? It seems that my patients were able to achieve this, but they had difficulties building a self representation, an idea of the self, an identity which integrates the various ego modalities.

Linnell poses the question: "Is there an evocative memory of the self which is required as a means to achieve self-cohesion or integration?" Or, when we follow Loewald's (1970) suggestion that one needs to focus on the representation of aspects of relationships rather than on the representational world, of the representational objects or past objects, then we have to assess the impact of the visual representational disorder on these relationships. Instead of relinquishing object and self representation, we have to link object representation with the nature of object relationships.

One will have to question whether these patients suffer from an ego disorder or a borderline condition. Such a diagnosis can be made more specific when we examine it in the context of the representational fault. This leads us to the influence of this disorder on psychoanalytic technique and reminds us of Anna Freud's (1970) prediction: "In our times, the analysts' therapeutic ambition goes beyond the realm of conflict and the improvement of inadequate conflict solutions. It now embraces the basic faults, failures, defects, and deprivations, i.e., the whole range of adverse external and internal factors, and it aims at the correc-

tion of their consequences. Personally, I cannot help feeling that there are significant differences between the two therapeutic tasks and that every discussion of technique will need to take account of these" (p. 202f.).

Robert Tyson and Phyllis Tyson (1986) discuss a similar point: "Often the child will try to use the analyst to fulfill a developmental need, for example, when a parent is depressed, absent, or suffering a prolonged illness. The analyst, by responsively and accurately interpreting the child's wishes and fantasies about him, provides a 'holding environment' (Winnicott, 1960) in which the child, while not physically held or gratified, is helped to find alternative means of gratification and control. Thus progressive structure-building and reorganization are facilitated, and development beyond the point of arrest becomes possible (Ritvo, 1978)" (p. 301).

We have referred to the primary disorder in visual object representation and to those disorders which are based on experiential failures. It is difficult to differentiate the consequences of these conditions on further development. The biological substrate of the ego equipment disorder makes studies of neurobiology relevant. I shall refer to two findings. In *Neuronal Man,* Changeux (1986) explores the development of nerve conditions that guide perceptions and memories. He postulates that an unstimulated neuron system leads to random, multiple connections. Furthermore, these random links stay labile over a period of time. This implies that stimulation by experience eliminates the random connections and consolidates into a coherent network only those which are task-specific. In the absence of appropriate stimulations, this differentiation does not occur and links are severed by the dearth of connection, which cannot be repaired. I should also like to refer to a specific organic brain disorder—prosopagnosia. The dictionary defines it as "inability to recognize faces and particularly a failure to react to the combination of those specific properties or features of an object that endow it with uniqueness. This may be congenital or acquired, but it rarely occurs as an isolated defect." In this condition the patients fail to recognize the face they ought to have known. These patients have lesions in both brain areas that link the visual system to regions involved in memory and emotions.

Thus, the facial templates which are formed by the eyes cannot be recalled.

The patients I have presented do not suffer from visual agnosis or prosopagnosia, but they have some symptoms which appear to be close to some aspects of this condition and one may therefore be inclined to pursue the neurophysiological substrates of both deficit disorders. Oliver Sacks in *The Man Who Mistook His Wife for a Hat* describes a case of visual agnosia and notes that it is especially the animate which is so absurdly perceived that "there is always a reaction on the part of the affected organism or individual, to restore, to replace, to compensate for, and to preserve its identity" (p. 21).

Hartmann (1939) addressed this issue in this way: "This distinction between a biological and a psychological *point of view* raises another important question: Can psychoanalysis, with its psychological . . . concepts, trace physiological processes of development? We reject the customary form of this question: What is biological and what is psychological in the developmental process? We ask instead: What part of it is congenital, and what maturational, and what environmentally determined? What physiological and what psychological changes take place in it? Our psychological method encompasses more than just the processes of mental development. Precisely because the psychological is part of the biological, under certain conditions our method sheds light on physiological developments, particularly on those pertaining to instinctual drives. We can trace the course of these developments, using psychological phenomena as their indicator or symptom" (p. 34f.).

I think we can be comfortable with some of these neurological findings for they correspond to our psychological propositions: the associative memory, the random activities which become more differentiated, and the definition of the disorder as a process disorder. The biologist also considers a multiplicity of specific interacting mechanisms. It is noteworthy not to exclude this dimension from our discussion.

As Hartmann (1939) states, "The biological usefulness of the inner world in adaptation, in differentiation, and in synthesis becomes obvious even in a brief glance at the biological significance of thought processes. Perception, memory, imagery,

thinking, and action are the relevant factors in this connection" (p. 58). In a further extension Hartmann explains that "autonomous ego development is one of the prerequisites of all reality relations . . . [and] for many other functions. Our arguments necessitated a detailed discussion of the ego apparatuses. In this connection, I stress again that no satisfactory definition of the concepts of ego strength and ego weakness is feasible without taking into account the nature and the maturational stage of the ego apparatuses which underlie intelligence, will, and action" (p. 107).

All my patients with failure of visual object representation showed two features which have relevance to child analysis. They were aware that this inability was part of their lives as long as they could remember. It is surprising, at least to me, that they were always aware of it. It should be possible therefore to detect it in childhood and certainly during child analysis.[1] As the child reveals his object relations, reenacts the role of the primary objects in play, we can observe the child's inner world, but it seems we do not explore the representational world. *It is the recognition of the difference between these worlds which offers the opportunity to locate more accurately the disorders,* by paying equal attention to both. Still, it may not be possible to elicit this information from young children, for they may not be able to articulate it. This leads to another aspect. As I have mentioned before, none of my patients spontaneously revealed the absence of visual representation, of the evocative memory. *When I asked* about it, they *were ready to reveal it.* This alone raises many unanswered questions about our patients, about *our* attitude toward addressing ourselves to their representational world, their cognitive readiness, their revelatory capacity about associations and secrets of childhood.

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